OPTOMETRIC AND EYEGLASS SERVICES

Ophthalmologists, Optometrists,
Opticians and Eyeglass Providers

Published By:

Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave Dept 325
Bismarck, ND 58505

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CONTACTS

PROVIDER ENROLLMENT

For enrollment changes or questions:
(800) 755-2604
(701) 328-4033

Send written inquiries to:
Provider Enrollment Unit
Medical Services
ND Dept. of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

PROVIDER RELATIONS

For questions about recipient eligibility, payments, denials, general claim questions, or to request provider manuals or fee schedules:
(800) 755-2604
(701) 328-4043
(701) 328-1714 Vision Consultant

Send written inquiries to:
Provider Relations
Medical Services
ND Dept. of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

CLAIMS

Send paper claims to:
Claims Processing
Medical Services
ND Dept. of Human Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505-0250

EYEGLASS CONTRACTOR

Walman Optical Company is contracted with DHS to provide eyeglasses to Medicaid clients. Providers should call VERIFY to ensure the client is eligible for eyeglasses or visit the Medifax website at www.medifax.com for additional information for online eligibility options.

(800) 428-4140 VERIFY phone #
(701) 328-2891 VERIFY phone #

TECHNICAL SERVICES CENTER

Providers who have questions or changes regarding electronic funds transfer should call the number below and ask for Provider Enrollment:
(800) 755-2604
(701) 328-4033

HIPAA/EDI ELECTRONIC DATA INTERCHANGE

For questions regarding electronic claims submissions:
701-328-2325

VERIFICATION OF ELIGIBILIY

MEDICAID

VERIFY is a recipient eligibility verification system provided by the State of North Dakota for the provider community. This system allows you to enter the patient identification number using a touchtone telephone and receive a verbal response from the computer indicating the name and date of birth of the patient; the patient's eligibility for a given date of service; Coordinated Services Program information; existence of any third party liability (TPL); and if so, the name of the TPL carrier; amount of recipient liability, if any; co-pay; dates of last eye exam, frames and lenses; and also the name of the primary care physician (PCP). All responses reflect the latest information available on the database at the time of the call.

The following page provides instructions that will guide you through the steps necessary to use the VERIFY system.

Upon Medifax membership, eligibility may be checked at the following web site: www.medifax.com

CSHS AND VOCATIONAL REHABILITATION

Children's Special Health Services (CSHS) and Vocational Rehabilitation (VR) eligibility information is not available on the VERIFY system. Eligibility for VR recipients must be determined by contacting the regional VR office. Eligibility for CSHS recipients must be determined by contacting the state CSHS office at 701-328-2436.

WOMEN'S WAY

Women's Way is a breast and cervical cancer early detection program available to eligible North Dakota women. Women who are determined to be eligible for Women's Way are entitled to full Medicaid coverage, including dental and vision. Women's Way eligibility information is not available on the VERIFY system. Women's Way recipient identification numbers begin with WW0000000. Eligibility for Women's Way recipients must be determined by contacting Medical Services at 701-328-1714.

VERIFY SYSTEM INSTRUCTIONS

FOR ALL VOICE RESPONSES

1. Dial (701) 328-2891 or 1-800-428-4140 (Receive Message)
2. Enter PROVIDER NUMBER and PRESS # (Receive Message)
3. Enter PATIENT ID NUMBER and PRESS # (Receive Message)
4. Enter DATE OF SERVICE and PRESS # (Receive Message)
5. Enter "2" if no more inquiries and to end call ***OR***
6. Enter "1" for additional inquiries and repeat 3 and 4 above.

FOR SPEED DIALING

1. Dial (701) 328-2891 or 1-800-428-4140 (Receive Message)
2. Enter PROVIDER NUMBER and PRESS #, PATIENT ID NUMBER and PRESS #, DATE OF SERVICE and PRESS # (Receive Message)
3. Enter "2" if no more inquiries and to end call ***OR***
4. Enter "1" for additional inquiries and repeat 2 above using PATIENT ID and PRESS # and DATE OF SERVICE and PRESS #

TO REPEAT INFORMATION

1. Enter "*" to repeat current message
2. Enter "1" for Eligibility and Recipient Liability
3. Enter "2" for Coordinated Services Program and Primary Care Physician (PCP)
4. Enter "3" for Co-Payment
5. Enter "4" for Third Party Liability (TPL)
6. Enter "5" for Vision
7. Enter "6" for ALL menu items

FOR CURRENT DATE, PRESS # KEY INSTEAD OF 8-DIGIT DATE

For prior authorization, print the form from our website listed below and fax to:

Anthony Mitchell OD
PO Box 1384
Williston ND 58802-1384
FAX: (701) 572-7444

PROVIDER INFORMATION WEBSITE http://www.state.nd.us/humanservices/	• Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms – **Vision Prior Authorization Form** • Provider enrollment • Newsletters • Key contacts • Links to other websites

COVERED SERVICES

GENERAL COVERAGE PRINCIPLES

This chapter provides covered services information that applies specifically to optometrists, opticians, and ophthalmologists. It also covers information for the prescription of corrective lenses. Like all health care services received by Medicaid clients, services provided by these practitioners must also meet the general requirements. Ophthalmologists should also be familiar with the *Physician Related Services* manual.

SERVICES WITHIN SCOPE OF PRACTICE

Services are covered when they are within the scope of the provider's practice, and are also a covered service by North Dakota Medicaid.

DISPENSING SERVICES

Dispensing services may be provided by ophthalmologists, optometrists, and opticians. Employees may also dispense as long as the provider complies with laws, rules, and licensing requirements regarding supervision and assistants or aides.

SERVICES FOR CLIENTS WITH LIMITED MEDICAID COVERAGE

Medicaid generally does not cover eye exams or eyeglasses for clients with QMB coverage. Always check client eligibility before providing services. However, Medicaid may cover eye exams for these clients under the following conditions.

- **Following cataract surgery**. Clients who have QMB only coverage are only eligible for eyeglasses following cataract surgery when Medicare approves the eyeglasses claim. Medicaid considers the Medicare coinsurance and deductible for this claim. Eyeglasses for these clients are not provided through the Department's eyeglass contractor but through Medicare's purchasing plan.

- **Diabetic diagnosis**. Medicaid covers eye exams for clients **with basic Medicaid coverage** not QMB, who have a diabetic diagnosis (see following table). Eyeglasses are not covered for these clients.

- **Certain eye conditions**. Medicaid covers eye exams for clients **with Basic Medicaid coverage** not QMB, who have certain eye conditions (see following table). Eyeglasses are not covered for these clients.

Diagnosis Codes for Which Basic Medicaid Covers Eye Exams			
360.0 - 366.9	374.5 - 377.9	379.29	870.0 - 871.9
368.1 - 368.2	379.00 - 379.19	379.31 - 379.39	918.1 - 918.9
368.40 - 368.47	379.23	379.54	930.0 - 930.1
370.0 - 372.39	379.26	279.8 - 379.99	076.0 - 077.99
372.6 - 374.23	V58.69	250.00 - 250.93	

NON-COVERED SERVICES

Some services not covered by Medicaid include the following:

- Services considered experimental or investigational.
- Dispensing fees for a client who is not eligible for lenses and/or frames within the three (3) year time period.
- Services that the provider did not personally provide. The main exception is that the dispensing service may be performed by the provider's employee when it is allowed by law.

IMPORTANCE OF FEE SCHEDULES

The easiest way to verify coverage for a specific service is to check the Department's fee schedule. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service. Use the current fee schedule for your provider type to verify coverage for specific services.

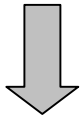
Current fee schedules are available on the Provider Information website http://www.state.nd.us/humanservices/services/medicalserv/medicaid/provider-fee-schedules.html. For hard copy, contact Provider Relations.

RETROACTIVE ELIGIBILITY

Medicaid **does not cover eyeglasses** for clients who become retroactively eligible for Medicaid when the eyeglasses were purchased before retroactive eligibility was determined. However, Medicaid does cover eye exams for retroactively eligible clients. For example, suppose that a client had an **eye exam** and purchased eyeglasses on July 15. On September 1, the Department determined the client was eligible for Medicaid retroactive to July 1. Medicaid would pay for the eye exam but not for the eyeglasses.

COVERAGE OF SPECIFIC SERVICES

The following are coverage rules for specific services provided by optometrists, opticians, and ophthalmologists. Due to limits on exams and eyeglasses, before providing these services, the provider should contact VERIFY or Medifax to ensure the client is currently eligible for an exam and to verify the client is eligible for eyeglasses. Medicaid will only pay for eyeglasses and frames purchased through the Department's eyeglass contractor. All services are subject to post payment review and payment recovery if they are not medically necessary.

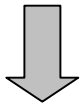


Medicaid will only pay for eyeglasses and frames purchased through the Department's eyeglass contractor.

CONTACT LENSES – PRIOR AUTHORIZATION REQUIRED

Contact lenses are covered only when medically necessary and not for cosmetic reasons. Dispensing providers must obtain prior authorization for all contact lenses and dispensing fees. The same limits that apply to eyeglasses and repairs also apply to contacts. Contact lenses are not provided by the eyeglass contractor and therefore may be provided by other providers. Medicaid covers them when the client has one of the following conditions:

- Keratoconus
- Sight that cannot be corrected to 20/40 with eyeglasses
- Aphakia
- Anisometropia of 2 diopters or more



If a provider does not check eligibility prior to an exam, and the claim is denied because the client's exam limit was exceeded, the provider cannot bill Medicaid or the client.

EYE EXAMS

Before providing an eye exam, verify that the client is eligible for an exam. Medicaid clients ages 21 and over are limited to one eye examination for determining refractive state every three (3) years. Medicaid clients ages 20 and under are limited to one eye examination for determining refractive state every 365 days. The Department allows exceptions to these limits when one of the following conditions exists:

- Following cataract surgery, when more than one exam during the respective period is necessary.
- Adult diabetic clients may have exams every 365 days.

EYEGLASS SERVICES

Before providing eyeglasses to a client, verify that the client is eligible. Adults ages 21 and older are eligible for eyeglasses every three (3) years. If the client has a diagnoses medical condition that prohibits the use of bifocals, Medicaid **requires a prior authorization for dispensing over**

the limit of single vision eyeglasses every three (3) years. The provider must document the client's inability to use bifocals. Children ages 20 and under are eligible for eyeglasses every 365 days.

FRAME SERVICES

The eyeglass contractor will provide a list of Medicaid-covered frames to dispensing providers.

Medicaid clients have the option of using their "existing frames" and Medicaid will cover lenses. The existing frame is a frame that the client owns or purchases. When a client chooses to use an existing frame, the following apply:

- Dispensing providers will evaluate existing frames to ensure lenses can be inserted.
- The eyeglass contractor will decide if the existing frame can be used for Medicaid covered lenses. If the existing frame cannot be used, the eyeglass contractor will inform the dispensing provider.
- If the existing frame breaks (after lenses are dispensed to the client), Medicaid will pay for a contract frame but not new lenses. The client can choose to pay privately for new lenses or find a contract frame that the lenses will fit. New lenses are not covered in this case.

LENS ADD-ONS

Medicaid covers some "add-on" or special features for eyeglass lenses, and some are available on a private pay basis (see table on next page).

Lens Add-Ons		
Lens Feature	**Medicaid Covers For Children (Ages 20 and Under)**	**Medicaid Covers For Adults (Ages 21 and Older)**
Photochromic - plastic (i.e. Transition)	Yes - if medically necessary with Prior Authorization	Yes – if medically necessary with Prior Authorization
Photochromic - Glass (i.e. photogray, photo-brown)	Yes - if medically necessary with Prior Authorization	No
Progressive	No, but Medicaid will pay our allowed and client must pay balance	No, but Medicaid will pay our allowed and client must pay balance
Polycarbonate lenses (Single vision, Bifocal, or Trifocal lenses)	Yes	Yes
Tints Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes	No
Tints other than Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes - if medically necessary with Prior Authorization	No
UV	Yes - if medically necessary with Prior Authorization	Yes - if medically necessary with Prior Authorization
Slab-off and fresnell prism	Yes - if medically necessary with Prior Authorization	Yes - if medically necessary with Prior Authorization

Any lens style, lens material, tint, coating lens enhancement (polished edge, etc.) not specifically noted above or within this manual will be billed to the dispensing provider at the contractor's normal and customary charges.

LENS STYLES AND MATERIALS

All eyeglass lenses fabricated by the eyeglass contractor for Medicaid clients must be in the edged form, edged to shape and size for a specific frame and returned to the dispensing provider as "lenses only," or edged and mounted into a specific frame and returned to the dispensing provider as "complete Rx order." Orders for "uncut" lenses are not accepted.

Medicaid covers the following lens styles:

- Single vision
- Flattop segments 28
- Round 22
- Flattop trifocals 7 x 28
- Executive style bifocals

Medicaid covers the following lens materials (no high index):

- Glass
- CR-39
- Polycarbonates

REPLACEMENT LENSES AND FRAMES

All frames provided by the Medicaid contractor carry a 12-month manufacturer warranty on replacement fronts and temples. Medicaid clients must bring their broken frames into the dispensing provider for the contractor to repair. No new frame style or color can replace the broken frame.

If an adult (ages 21 and older) loses his or her eyeglasses within the 36 months, Medicaid will not cover another pair.

If a child (ages 20 and under) loses or breaks the first pair of eyeglasses, and the damage is not covered by the warranty, Medicaid will replace one pair of eyeglasses within the 12 month period, all replacement requests must be prior authorized by the Department.

EYEGLASS ORDERING PROCEDURES

Providers must complete the North Dakota Medicaid Rx form to order eyeglasses from the Department's contractor.

Rx change is used when a lens is ordered due to a prescription change, which meets Medicaid guidelines.

SUBMITTING THE MEDICAID RX FORM

- Mail or fax the order form to the eyeglass contractor. Phone orders are not accepted. To ensure orders will be processed accurately and on time, all sections of the order form must be completed.

- Errors in the fabrication of eyeglasses made by the eyeglass contractor will be corrected by the contractor at no additional charge.

PRIOR AUTHORIZATION

Some services require prior authorization (PA) before providing them. When seeking PA, keep in mind the following:

- The Performing/Rendering provider should initiate all authorization requests. Requests for authorization must be submitted in writing or by fax.
- Have all required documentation included when submitting for PA.

PA Criteria for Specific Services	
Service	**Documentation Requirements**
Dispensing and fitting of contact lenses	PA required for contact lenses and dispensing fees. Diagnosis must be one of the following: • Keratoconus • Aphakia • Sight cannot be corrected to 20/40 with eyeglasses • Anisometropia of 2 diopters or more
Transition lenses **Tints other than Rose 1 and Rose 2 (including photochromic tints)** **UV and scratch resistant coating**	Include diagnosis and sufficient documentation from the optometrist or ophthalmologist that transition lenses, tints, or UV and scratch resistant coating are medically necessary.
Eye prosthesis	Documentation that supports medical necessity. Documentation regarding the client's ability to comply with any required after care. Letters of justification from rendering physician. Documentation should be provided at least two weeks prior to the procedure date.
Vision Training (CPT code 92065) Recipients under 21	Documentation that supports medical necessity; Guidelines: • Binocular vision • Amblyopic lazy eye • Eye turn problems that need therapy, but does not require surgery.

COORDINATION OF BENEFITS

WHEN CLIENTS HAVE OTHER COVERAGE

Medicaid clients often have optical services coverage through Medicare, Workforce Safety Insurance, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions.

WHEN A CLIENT HAS MEDICARE

Medicare Part A Claims

Medicare Part A covers inpatient hospital care, skilled nursing care and other services. Medicare Part A services are covered in more detail in specific program manuals where the providers bill for Part A services.

Medicare Part B Crossover Claims

Medicare Part B covers physician care, eye exams, and other services. The Department has an agreement with Medicare Part B carriers for North Dakota (Blue Cross Blue Shield of ND). Under this agreement, the carriers provide the Department with a magnetic tape of CMS-1500 (formerly HCFA-1500) claims for clients who have both Medicare and Medicaid coverage. In order to have claims automatically cross over from Medicare to Medicaid, the provider must:

- Accept Medicare assignment (otherwise payment and the Explanation of Medicare Benefits (EOMB) go directly to the client and will not cross over).
- Submit their Medicare and Medicaid provider numbers to Provider Enrollment.

In these situations, providers need **NOT** submit Medicare Part B claims to Medicaid. Medicare will process the claim, submit it to Medicaid, and send the provider an EOMB. Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit.

When Medicare Pays or Denies a Service

- When Medicare pays an eye exam claim for a provider that is set up for automatic crossover, the claim should automatically cross over to Medicaid for processing, so the provider does not need to submit these claims to Medicaid.

  Providers that are not set up for automatic crossover should submit a claim to Medicaid with EOMB after Medicare pays, and Medicaid will consider the claim for payment.

  If Medicare denies an eye exam claim, they are to submit the claim with EOMB to Medicaid.

- Clients who have Medicare/QMB or Medicare/Medicaid coverage must choose whether to access their Medicare or Medicaid benefits for eyeglasses. If a client chooses to use Medicare, do not bill Medicaid, and any claims that cross over from Medicare will be denied.

- For clients who have QMB only coverage, the provider bills Medicare first for eyeglass claims, and if Medicare pays the claim, Medicaid will process the claim for coinsurance and deductible. If Medicare denies the claim, Medicaid will also deny the claim.

When Medicaid does not respond to crossover claims

When Medicaid does not respond within 45 days of the provider receiving the Medicare EOMB, the provider should submit a claim, with a copy of the Medicare EOMB, to Medicaid for processing.

Submitting Medicare claims to Medicaid

When submitting a paper claim to Medicaid, attach the Medicare EOMB and use Medicaid billing instructions and codes. The claim must also include the Medicaid provider number and Medicaid client ID number.

WHEN A CLIENT HAS TPL

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability or TPL. In most cases, providers must bill other insurance carriers before billing Medicaid.

Exceptions to Billing Third Party First

In a few cases, providers may bill Medicaid first:

- When a Medicaid client is also covered by the Crime Victim's Compensation Fund, providers must bill Medicaid before Crime Victim's. These are not considered third party liability.
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim. Instead, notify the Department of the potential third party by sending the claim and a note to Third Party Liability Unit.

When Third Party Pays or Denies a Service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid in the "amount paid" field of the claim when submitting to Medicaid for processing. These claims may be submitted either electronically or on paper.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance Explanation of Benefits (EOB) when billing Medicaid. These claims must be submitted on paper.
- Denies the claim, include a copy of the denial (including the reason and the reason explanation) with the claim, and submit to Medicaid.
- For paper claims only. Denies a line on the claim, bill the denied lines together on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

When Third Party Does Not Respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Attach to the claim a note explaining that the insurance company has been billed (or attach a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the Third Party Liability Unit.

BILLING PROCEDURES

CLAIM FORMS

Services provided by optometrists, opticians, and ophthalmologists must be billed either electronically on a Professional claim (HIPAA 837-P) or on a CMS-1500 paper claim form (formerly known as the HCFA-1500). CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

TIMELY FILING LIMITS

Providers must submit clean claims to Medicaid within the latest of:

Twelve months from whichever is later:

- The date of service
- The date retroactive eligibility or disability is determined

- **Medicare Crossover Claims:** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).

- **Claims involving other third party payers (excluding Medicare)**: Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department, Clearinghouse, or Billing Agency.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly.
- If a claim submitted to Medicaid does not appear on the remittance advice within 60 days, contact Provider Relations for claim status.
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid.

WHEN TO BILL MEDICAID CLIENTS

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid. The main exception is that providers may collect recipient liability from clients.

More specifically, **PROVIDERS CANNOT BILL** clients directly:

- For the difference between charges and the amount Medicaid paid.
- When a third-party payer does not respond.
- When a client fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments either.
- When services are free to the client, such as in a public health clinic. Medicaid may not be billed for those services either.

USUAL AND CUSTOMARY CHARGE

Providers must bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service.

WHEN CLIENTS HAVE OTHER INSURANCE

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client's health care.

BILLING FOR RETROACTIVELY ELIGIBLE CLIENTS

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the eligibility determination letter to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) and bill Medicaid for the service(s).

PLACE OF SERVICE

Place of service must be entered correctly on each line. Medicaid typically reduces payment for services provided in hospitals and ambulatory surgical centers since these facilities typically bill Medicaid separately for facility charges.

MULTIPLE VISITS ON SAME DATE

Medicaid generally covers only one dispensing fee per client per day, unless two pairs of single vision eyeglasses are dispensed (distance/near).

When a client requires additional visits on the same day, use a modifier to describe the reason for multiple visits. When a modifier is not appropriate for the situation, attach documentation of medical necessity to the claim, and submit for review.

CODING

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the table of Coding Resources on the following page. The following suggestions may help reduce coding errors and unnecessary claim denials;

- Use current CPT-4, HCPCS Level II, and ICD-9-CM coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Follow CPT-4 guidelines on the difference between a new patient and an established patient.
- Bill for the appropriate level of service provided. For example, the CPT-4 coding book contains detailed descriptions and examples of what differentiates a level I established patient office visit (99211) from a level 4 office visit (99214).
- Services covered within “global periods” for certain CPT-4 procedures are not paid separately and must not be billed separately. Most surgical and some medical procedures include routine before and after the procedure. Medicaid fee schedules show the global period for each CPT-4 service.
- Use the correct number of units on CMS-1500 claims. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II coding manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be 15 minutes. Always check the long text of the code description.
- CPT codes that are billed based on the amount of time spent with the client must be billed with the code that is closest to the time spent. For example, a provider spends 60 minutes with the client. The code choices are 45 to 50 minutes or 76 to 80 minutes. The provider must bill the code for 45 to 50 minutes.

Coding Resources **Please note that the Department does not endorse the products of any particular publisher**		
Resource	**Description**	**Contact**
ICD-9-CM	ICD-9 CM diagnosis and procedure codes definitions. Updated each October.	Available through various publishers and bookstores American Optometric Association (800) 365-2219
CPT-4	CPT-4 codes and definitions Updated each January	American Medical Association (8000 621-8335 www.amapress.com or Medicode (Ingenix) www.medicode.com or www.ingenixonline.com or American Optometric Association (800) 365-2219 www.aoanet.org
HCPCS Level II	HCPCS Level II codes and definitions Updated each January and throughout the year	Available through various publishers and bookstores or from CMS at cms.hhs.gov/paymentsystems/hcpcs/2001rel.asp
CPT Assistant	A newsletter on CPT-4 coding issues	American Medial Association (800) 621-8335 www.amapress.com
Miscellaneous Resources	Various newsletters and other coding resources	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/product/correct-coding.htm

USING MODIFIERS

- Review the guidelines for using modifiers in the most current CPT-4, HCPCS Level II, or helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- When billing with modifier 50 for bilateral services, put all information on one line with one unit. You do not need to use modifiers for left and right, and do not bill on separate lines.
- Check the fee schedule to see if Medicaid allows the use of the following modifiers for a particular code: bilateral (50), multiple procedures (51), co-surgery (62), assistant at surgery (80, 81, 82, AS, and team surgery (66).

BILLING TIPS FOR SPECIFIC SERVICES

Bundled Services

Certain services with CPT-4 or HCPCS codes (e.g., tear duct plugs) are covered by Medicaid but have a fee of zero. This means that the service is typically "bundled" with an office visit or other service. Since the bundled service is covered by Medicaid, providers may not bill the client separately for it.

Contact Lenses

When billing Medicaid for contact lenses, include the prior authorization number on the claim (field 23 of the CMS-1500 form) and a copy of the invoice.

Eye Exams

- A client may be eligible for an eye exam before the specified time limit expires if he or she meets the criteria. In this case, enter the reason for the exam on the claim (box 19 of the CMS-1500 claim form).
- Medicare does not cover eye refraction (92015) but instructs providers to report this service as a separate line item from the other service(s) performed. Medicaid covers this procedure, so providers can bill for the eye exam and the refraction.
- Children (age 20 and under may receive an additional exam with prior authorization before the 365-day limit has passed if they have had at least a one line acuity change resulting in prescribing replacement.

Eyeglass Services

- Adult clients (ages 21 and older) may receive new lenses with prior authorization before the three (3) year limit has passed if they meet the criteria described the Eyeglass Services section of the Covered Services chapter in this manual. Children (age 20 and under) may receive new lenses with prior authorization before the 365-day limit has passed if they meet the criteria in the Eyeglass Services section of the Covered Services chapter in this manual. In this case, providers may bill Medicaid for a dispensing fee for new lens.
- If the adult Medicaid client (age 21 and over) is not eligible for lens(es) and/or frame within the three (3) year period (see Covered Services Chapter, Eyeglass Services), the dispensing provider may not bill Medicaid for a dispensing fee. If the client chooses to purchase eyeglasses privately, the provider may bill the Medicaid client for dispensing services and eyeglass materials.
- The eyeglass contractor will bill Medicaid for the laboratory and material costs for lenses and frames.

Frame Services

- When the Medicaid client uses an existing frame, the dispensing provider bills Medicaid for dispensing services, lenses only.
- Providers may not charge a dispensing fee for minor frame repairs that they provide themselves.
- If a client that is covered by Medicare Part B and Medicaid chooses a frame outside the Medicaid contract, the provider cannot bill Medicaid for the dispensing fee. All charges must be billed to Medicare and the client.

Lens Add-ons

The eyeglass contractor bills the dispensing provider their usual and customary charge for any lens style, lens material, tint, coating lens enhancement (polished edge, etc.) not covered by Medicaid (see Covered Services, Lens add-ons). It is the dispensing provider's responsibility to bill the Medicaid client for these items. Do not bill Medicaid.

Replacement Lenses and Frames

If a client has selected to use an existing frame, and the existing frame breaks after lenses were dispensed to the client, Medicaid will not cover new lenses. The Medicaid client may privately pay for new lenses or select a contract frame that the existing lenses will fit into. If a contract frame is selected, the dispensing provider may bill Medicaid for dispensing services, frame only.

SUBMITTING ELECTRONIC CLAIMS

The N.D. Department of Human Services (DHS) will no longer accept electronic claims that are not in the HIPAA compliant format.

- Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the methods listed below.

To test HIPAA transactions contact Medical Services at (701) 328-2325.

1) Web File Transfer

- The Department is accepting 4010A transactions (837-P and 837-I) with providers. As providers submit their completed TPA, EDI, and EFT forms, the Department enters the forms and then contacts providers to schedule testing times.

- The Department is encouraging the use of its Web File Transfer.

- Also, in order to reduce administrative expenses, the Department is encouraging submission through the web, rather than using clearinghouses. The clearinghouses charge the Department a per claim fee.

2) Clearinghouse.

- Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through the Claredi before submitting claims to the clearinghouse.

CLAIM INQUIRIES

Our website http://www.state.nd.us/humanservices/ contains billing instructions, manuals, notices, fee schedules, answers to commonly-asked questions and much more. The information may be downloaded and shared with others in your office. If you cannot find answers to your questions on the website, or if you have questions on a specific claim, contact Provider Relations.

Provider Relations will respond to the inquiry within 24 hours. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

THE MOST COMMON BILLING ERRORS AND HOW TO AVOID THEM

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reason for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 9-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or handwritten.
Signature date missing	Each claim must have a signature date.

COMMON BILLING ERRORS	
Reason for Return or Denial	**Reason for Return or Denial**
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form or electronic Professional claim 837P.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: View the client's ID card at each visit. Medicaid eligibility may change monthly. Verify client eligibility by using one of the methods described in the Client Eligibility and Responsibilities chapter found earlier in this manual.
Duplicate claim	Please check all remittance advices (RAs) for previously submitted claims before resubmitting. When making changes to previously paid claims, submit an adjustment form rather than a new claim (see Remittance Advices and Adjustments in this manual). Please allow 45 days from the date they receive the MEOB, not DOS, for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Medicare Part B crossover claims submitted before Medicare's 45-day crossover limit	Claims that cross over between Medicare Part B and Medicaid should not be billed on paper to Medicaid until 45 days after the Medicare Part B paid date. These claims will be returned to the provider.
Prior authorization number is missing	Prior authorization (PA) is required for certain services, and the PA number must be on the claim.
TPL on file and no credit amount on claim	If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. If the client's TPL coverage has changed, providers must notify the TPL unit before submitting a claim.
Claim past 365-day filing limit	The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. To ensure timely processing, claims and adjustments must be mailed to Claims Processing.
Missing Medicare EOMB	All Medicare crossover claims on CMS-1500 forms must have an Explanation of Medicare Benefits (EOMB) attached, and be billed to Medicaid on paper.

COMMON BILLING ERRORS	
Reason for Return or Denial	**Reason for Return or Denial**
Provider is not eligible during dates of services, or provider number terminated	Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. New providers cannot bill for services provided before Medicaid enrollment begins. If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Type of service/procedure is not allowed for provider type	Provider is not allowed to perform the service, or type of service is invalid. Verify the procedure code is correct using current HCPCS and CPT-4 billing manual.

COMMON CLAIMS ERRORS

Common Claims Errors	
Claim Error	**Prevention**
Required field is blank	Check the claim instructions after this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required field; verify that the client's Medicaid ID number is listed as it appears on the client's ID card.
Client name missing	This is a required field; check that it is correct.
Medicaid provider number missing or invalid	The provider number is a 9-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in field 23 (see Prior Authorization in this manual).
Not enough information regarding other coverage	Fields 1a and 11d are required fields when a client has other coverage (refer to the examples earlier in this chapter).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or handwritten.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Medicare EOMB not attached	When Medicare is involved in payment on a claim the Medicare EOMB must be attached to the claim or it will be denied.

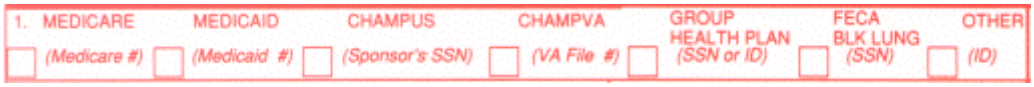
North Dakota Medicaid CMS-1500 Claim Form Billing Instructions

Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave, Dept 325
Bismarck, ND 58505

January 2005

Block (1) PAYOR CODE:

Enter an X in the Medicaid box.



Block (1a) INSURED'S I.D. NUMBER:

This field is required. Enter the printed 9-digit North Dakota Medicaid Recipient Identification number shown on the eligibility card provided to recipients by Medical Services. The number must be entered without slashes, hyphens, or spaces. Do not enter the recipient's Social Security Number, as this is not accepted.

Block (2) PATIENT'S NAME:

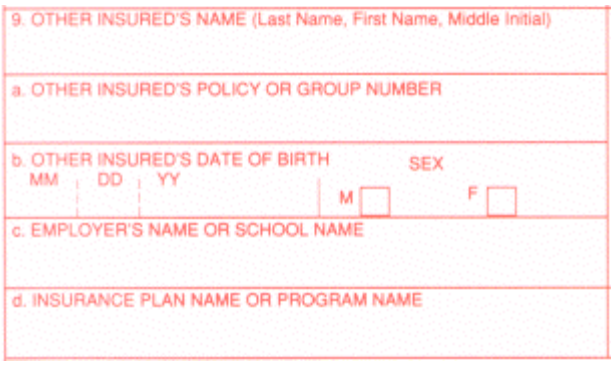
This field is required. Enter the recipient name as it appears on the eligibility card provided to recipients by Medical Services. Enter the recipient name in Last Name, First Name, Middle Initial (if present) format. USE ALL CAPITAL LETTERS.

Block (3) PATIENT'S BIRTH DATE:

This field is required. Enter recipient's birth date in MMDDYY format and enter an 'X' in the appropriate box for the recipient's gender.

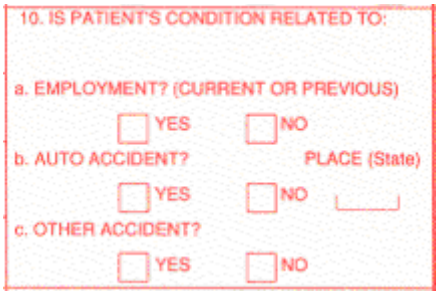
Block (9) OTHER INSURED'S NAME:

This field is required when applicable. If the recipient has other medical insurance coverage and he/she is not the policyholder (e.g., a child has coverage under a parent's policy), enter the policyholder's name and complete boxes 9a-9d. If no other insurance, leave 9-9d blank.



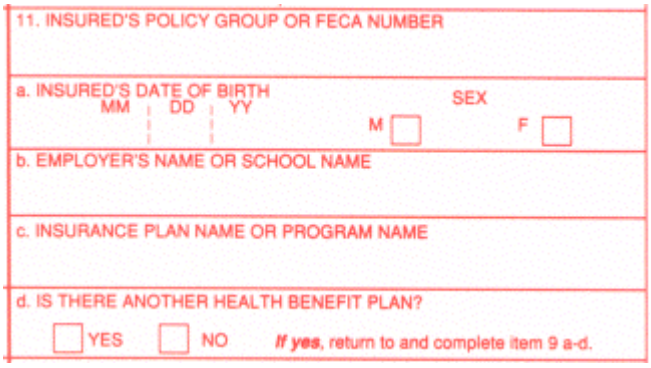
Block (10) IS PATIENT'S CONDITION RELATED TO:

This field is required when applicable. Enter an 'X' in all blocks that are applicable.



Block (11) INSURED'S POLICY GROUP OR FECA NUMBER:

This field is required when applicable. Enter an 'X' and/or information in all blocks that are applicable.



Block (17) NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:

This field is required when applicable. Enter physician's name if applicable.

Block (17a) I.D. NUMBER OF REFERRING PHYSICIAN:

This field is required when applicable. Enter the physician's North Dakota Medicaid provider number or the physician's UPIN in this block if applicable.

Block (21) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:

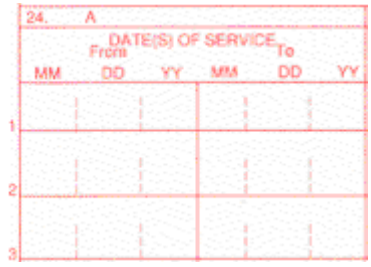
This field is required. We require a medical diagnosis from the ICD-9-CM. Enter up to four ICD-9-CM diagnosis codes in descending order.

Block (23) PRIOR AUTHORIZATION NUMBER:

This field is required when applicable.

Block (24A) DATES OF SERVICE:

This field is required. Enter the 'From' date of service in the MMDDYY format. If services were provided for additional consecutive days you should complete the 'To' date column in the MMDDYY format.



Block (24B) PLACE OF SERVICE:

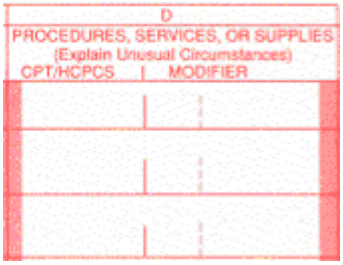
This field is required. Enter the appropriate place of service code.

11 Office
12 Home Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room Hospital

24 Ambulatory Surgical Center
31 Skilled Nursing Facility
54 Intermediate Mental Health Care Facility
81 Independent Laboratory
99 Other Unlisted Facility

Block (24D) PROCEDURE CODE:

This field is required. Enter the appropriate CPT/HCPCS code, including any applicable modifiers.

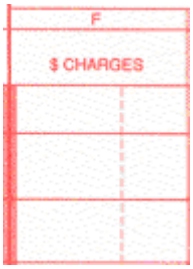


Block (24E) DIAGNOSIS CODE

Enter the appropriate number(s) (1, 2, 3, and/or 4) from Block 21 that correspond to the procedure/service on each line.

Block (24F) CHARGES

This field is required. Enter the usual and customary charge for the procedure/service in this block. Do not use dollar signs, decimals, or spaces. Providers are required to bill their usual and customary charge. The department captures this information to track payment levels. If a third party paid on the claim, enter the billed amount less any discounts or service benefit credits.



Block (24G) DAYS OR UNITS

This field is required. Enter the number of units for the procedure/service.

Block (24H) EPSDT/FAMILY PLAN

This field is required. This block is used to track Family Planning claims. Enter a 'Y' in this block if the service is a result of a Family Planning referral.

Block (24K) RESERVED FOR LOCAL USE

This field is required when applicable. If the billing provider in Block 33 is an *individual* practice, this block does not need to be filled out. If the billing provider in Block 33 is a *group* practice, you must enter the North Dakota Medicaid provider number or the UPIN of the provider who **rendered** the service.

Block (25) FEDERAL TAX I.D. NUMBER

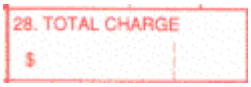
This field is required. Enter the providers Federal Tax Identification number.

Block (26) PATIENT ACCOUNT NUMBER

This field is optional. The provider may enter their account number for the recipient. This number will be included on the remittance advice.

Block (28) TOTAL CHARGE

This field is required. Enter the sum of all charges on the claim. Do not use dollar signs, decimals, or spaces.



Block (29) AMOUNT PAID

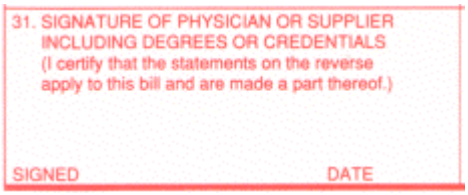
This field is required when applicable. If there is other insurance or another responsible party, the provider must collect from the other source of payment prior to billing North Dakota Medicaid. Attach a copy of the EOB (Explanation of Benefits) from the third party to the claim form. If a patient has court ordered coverage, the provider must collect from the source of the payment prior to billing North Dakota Medicaid. If there is no other insurance coverage indicated, the provider should leave this block blank. Do not enter copayments, prior NDMA payments, or recipient liability amounts.

Block (30) BALANCE DUE

This field is required. Enter the results of blocks (28) and (29). The Total Charges less Other Insurance = Balance Due. This is the amount the provider is requesting as payment from NDMA.

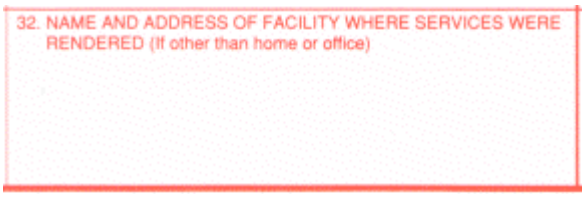
Block (31) SIGNATURE OF PROVIDER

This field is required. The provider or assigned representative must sign and date the claim in this block. By signing the claim, the provider agrees to and is certifying that the statements made by him/her are correct and justified. Signature stamps or computer-generated signatures are acceptable in conjunction with the signature on our provider enrollment form.



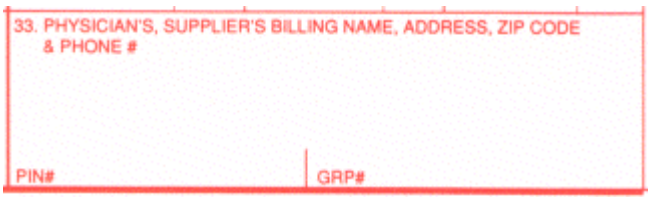
Block (32) NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED

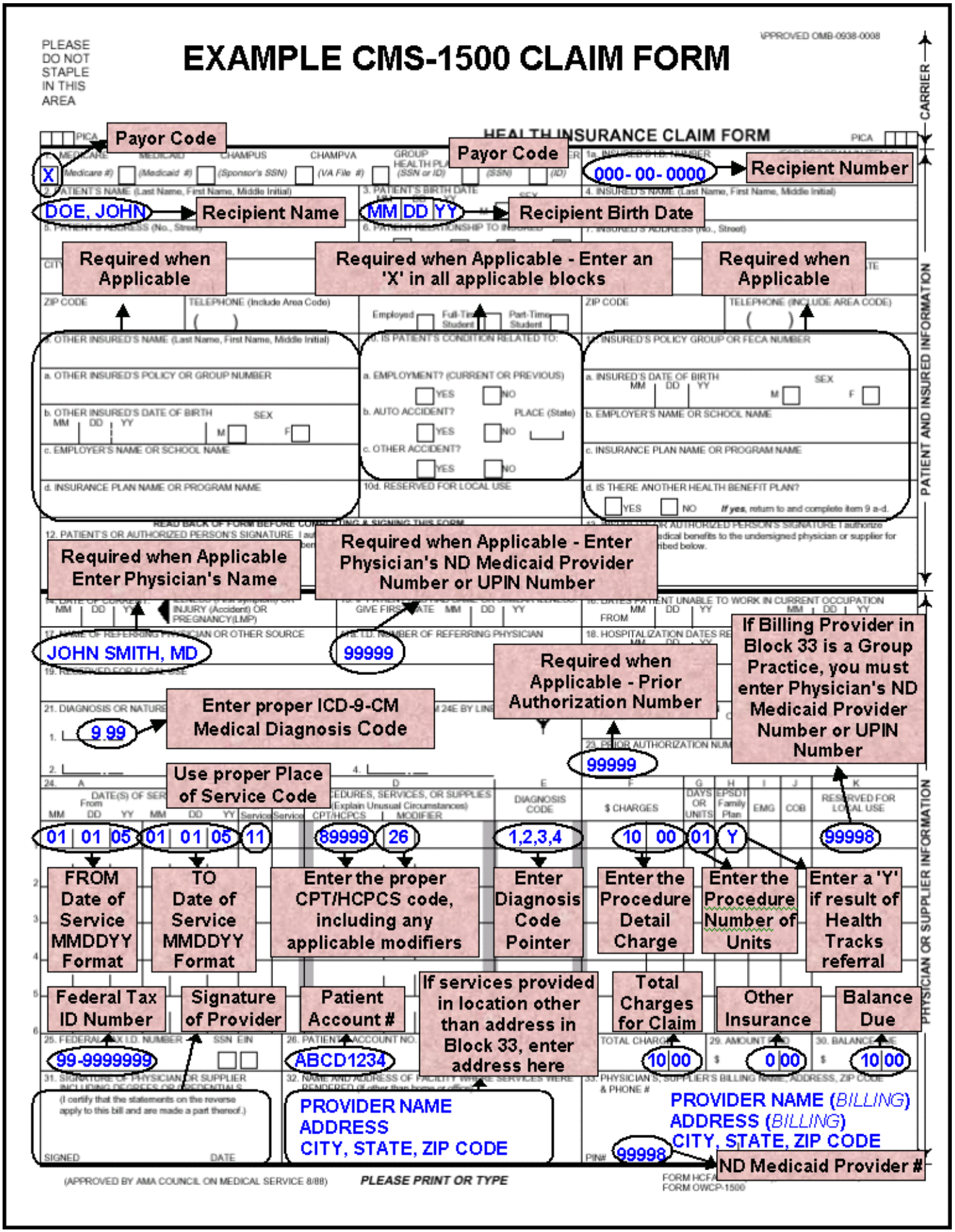
This field is required when applicable. If services were provided somewhere other than the address listed in Block 33 or in the recipient's home, enter the facility name and address.



Block (33) PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE

This field is required. Enter the provider billing name and address. If the provider is an individual practice, enter the ND Medicaid Provider number in 'GRP#'. If the provider is a group practice, enter the group ND Medicaid Provider number in 'GRP#' and the performing physician in Block 24K.




EXAMPLE CMS-1500 CLAIM FORM
PLEASE DO NOT STAPLE IN THIS AREA
APPROVED OMB-0938-0008
HEALTH INSURANCE CLAIM FORM
CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
Payor Code
Payor Code
X
000-00-0000
Recipient Number
DOE, JOHN
Recipient Name
MM DD YY
Recipient Birth Date
Required when Applicable
Required when Applicable - Enter an 'X' in all applicable blocks
Required when Applicable
Required when Applicable Enter Physician's Name
Required when Applicable - Enter Physician's ND Medicaid Provider Number or UPIN Number
JOHN SMITH, MD
99999
Required when Applicable - Prior Authorization Number
If Billing Provider in Block 33 is a Group Practice, you must enter Physician's ND Medicaid Provider Number or UPIN Number
99999
Enter proper ICD-9-CM Medical Diagnosis Code
9.99
Use proper Place of Service Code
01 01 05
01 01 05
11
89999
26
1,2,3,4
10 00
01
Y
99998
FROM Date of Service MMDDYY Format
TO Date of Service MMDDYY Format
Enter the proper CPT/HCPCS code, including any applicable modifiers
Enter Diagnosis Code Pointer
Enter the Procedure Detail Charge
Enter the Procedure Number of Units
Enter a 'Y' if result of Health Tracks referral
Federal Tax ID Number
Signature of Provider
Patient Account #
If services provided in location other than address in Block 33, enter address here
Total Charges for Claim
Other Insurance
Balance Due
99-9999999
ABCD1234
10 00
0 00
10 00
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED
DATE
PROVIDER NAME
ADDRESS
CITY, STATE, ZIP CODE
PROVIDER NAME (BILLING)
ADDRESS (BILLING)
CITY, STATE, ZIP CODE
99998
ND Medicaid Provider #
(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
PLEASE PRINT OR TYPE
FORM HCFA
FORM OWCP-1500

REMITTANCE ADVICES AND ADJUSTMENTS

THE REMITTANCE ADVICE

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services provided. The RA provides details of all transactions that have occurred during the previous week. Each line of the RA represents all or part of a claim, and explains exactly what has happened to the claims (paid, denied) and the reason the claim was denied.

Paper Remittance Advice

KEY FIELDS ON THE REMITTANCE ADVICE

FIELD	DESCRIPTION
1. Date	The date the RA was issued
2. Provider number	The 9-digit number assigned to the provider after enrollment
3. Check or ACH number	System assigned # to check or Automated Clearinghouse (ACH) transaction
4. Page number	The page number of the RA
5. RA #	State assigned number
6. Provider name and address	Provider's business name and address as recorded with the Department
7. Internal control number (ICN)	Each claim is assigned a unique 13-digit number (ICN). Use this number when you have any questions concerning a claim.
8. Recipient ID	The client's Medicaid ID number
9. Name	The client's name
10. Case #	The 10-digit number assigned by the local county social service agency.
11. Patient control #	The number assigned by the provider.
12. Performing Physician	The number assigned to the performing provider.
13. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same will appear in both columns.
14. Procedure/revenue/NDC	The procedure, revenue, HCPCS, or NDC# billed will appear in this column. If a modifier was used, it will also appear in this column.
15. Unit of service	The number of services provided under this procedure code.
16. Billed charges	The amount a provider billed for this service.
17. Recipient liability or other insurance	Amount deducted due to recipient liability or other insurance payment.

FIELD	DESCRIPTION
18. Payment	Medicaid's allowed amount. The Medicaid payment may not be allowed amount if there is OI or RL.
19. Message/Explanation of Benefits (EOB)	A code that explains how or why the specific service was denied or paid. These codes and their meanings are listed at the end of the Remittance Advice.
20. Third Party Liability (TPL)	If applicable, name of third party payer will be listed.
21. Co-pay/deductible information	Indicated amount deducted that is recipient responsibility.
22. Total charge/payment amount	Total of claims on remittance advice, and total of charges billed by provider.
23. Explanation of message codes used above	Summary of codes that were used to pay or deny a service.

PAYMENT AND THE RA

Providers may receive their Medicaid payment and remittance advice weekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. The Department encourages EFT as providers receive payment sooner, and it is less costly for the Department.

With EFT, the Department deposits the funds directly to the provider's bank account. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

The form may be obtained from our web site at Provider Online Forms: Medicaid: Medical Services: Services: Department of Human Services: State of North Dakota. To participate in EFT, providers must complete a SFN 661. One form must be completed for each provider number.

Once electronic transfer is established, all Medicaid payments will be made through EFT. For questions or changes regarding EFT, contact Provider Enrollment.

(Sample of Remittance Advice (RA) has been provided on the next page.)

(**1**)09/17/04 NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL ASSISTANCE
(**2**)Provider Number 012345 REMITTANCE ADVICE (**4)**Page 1
(**3**)Check Number (or ACH) 00000001 (**5**)R/A Number 14

(**6**) Main Street Clinic
Anytown, USA

Control No.	ID Number	Recipient Name	Case Number	Pat. Control Num	Prog. ID	
P.Phys	Service Dates	RX. No.	Service	Code/Mod	QTY	Billed	RL/OI	Payment	MSG
	(**7)**	(**8**)	(**9**)	(**10**)	(**11**)				
1	1004162304510	000-11-1234	Mouse Mickey	02-00015-007	415503840				
	(**12)**	(**13**)	(**14**)	(**15**)	(**16**)	(**17**)	(**18**)	(**19**)	
2	000052565	052604-052604		99214	1.0	132.00	.00	.00	22
	(**20**)								
	TPL Carrier Code: 0382 Name: Workers Compensation								
	(**7**)	(**8**)	(**9**)	(**10**)	(**11**)				
1	1004162304500	000-00-5555	Duck Daisy	23-00023-203	041550106				
	(**12**)	(**13**)	(**14**)	(**15**)	(**16**)	(**17**)	(**18**)	(**19**)	
2	000036529	052404-052404		99243	1.0	177.00	.00	96.17	N14
(**21**)									
Collect this co-pay amount from the recipient							2.00		
(22)TOTAL CHARGE/Payment Amounts					2	309.00	96.17		

(**23**) Explanation of message codes used above
22 Payment adjusted because this care may be covered by another payer per coordination of benefits
N14 Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount

Credit Balances

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

- By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
- By sending a check payable to NDDHS for the amount owed. This method is required for providers who no longer submit claims to Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the Provider Relations Field Representative at the Provider Relations address in Key contacts.

REBILLING AND ADJUSTMENTS

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit or adjust any initial claim within the timely filing limits.
- These time periods do not apply to overpayments that the provider must refund to the Department. The provider may refund overpayments by issuing a check.

When to Re-bill Medicaid

- **Claim Denied.** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Explanation of Benefits (EOB) code, make the appropriate corrections, and resubmit the corrected claim on a CMS-1500 form (not the adjustment form).

- **Line Denied.** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Submit the denied service on a new CMS-1500 form. (Do not use an adjustment form.)

- **Claim Returned.** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to Re-bill

- Check any EOB code listed and make your corrections on a new claim with the correct information.
- When making corrections on a claim, remember the claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations or the provider may submit an Individual Adjustment Request form to Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction.

When to Request an Adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

How to Request an Adjustment

To request an adjustment, use the ND Medicaid Individual Adjustment Request form. The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the payment date.
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.

- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the Remarks section of the adjustment form.

Completing an Adjustment Request Form

- Copy the North Dakota Medicaid Individual Adjustment Request form. You may also download the form from the website at http://www.state.nd.us/eforms/. Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
- Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):

COMPLETING AN ADJUSTMENT REQUEST FORM

The adjustment should be completed as it appears on the Remittance Advice.

Field	Description
(1) Reason for Request	Check appropriate box
(2) Recipient Block: a. I.D. Number (9 digits) b. State Use Only c. Patient's Name d. Case Number (10 digits)	Medicaid ID number Leave blank The recipient's name is here. 10 digit number assigned by the county
(3) Provider's Name	Provider's name and address (and mailing address if different)
(4) Claim's Internal Control Number: (13 digits)	There can be only one ICN per Adjustment Request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
(5)	Leave blank
(6) Provider Number	The provider's Medicaid ID number
(7) Remittance Advice Date (MM/DD/YY)	Date claim was paid found on Remittance Advice Field #1 (see the sample RA in the Remittance Advice Chapter)
(8) Date of Service:	The date the service was provided
(9) Units	Units/days of service.
(10) Place of Service	Where the service was provided
(11) Procedure/Ancillary/ Accommodation Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
(12) Mod	Modifier.
(14) Amount Billed	The amount billed by the provider.
(15) Amount Paid	The amount reimbursed by the department for that service.
(16) Total	The amount reimbursed by the department for the entire claim.
(17) Explanation/Remarks	The reason for adjusting the claim. Explain in detail.
(19) Provider's Signature	Signature, date, and telephone number of person initiating the adjustment.

north dakota department of human services

North Dakota Department of Human Services
Medical Services Division
600 E Boulevard Ave. Dept. 325
Bismarck, ND 58505-0250
701-328-4030 – Fax: 701-328-1544

REQUEST FOR PRE-AUTHORIZATION OF VISION SERVICES

Date: _____ Patient Name: _____

Medicaid ID#: _____ Address: _____

Birth Date: _____ _____

PROVIDER INFORMATION

Name/Address: _____ Provider #: _____

_____ Telephone: _____

_____ FAX: _____

Signature: _____ Date: _____

PRE-AUTHORIZATION REQUESTED (circle applicable):

Other Procedure Exam Refraction Frame Lens: Right Left

Medical Necessity (Required): _____

_____

_____

Appointment Date_____

Date of Previous Eye Exam: _____/_____/_____ Date of Previous Lens: _____/_____/_____ Date of Previous Frame: _____/_____/_____	Present Rx: Sph / Cyl / Axis OD _____ _____ x _____ OS _____ _____ x _____	Add _____ _____	**Visual Acuity** VA / HOTV ____/____ ____/____	Prism _____ _____
	New Rx: Sph / Cyl / Axis OD _____ _____ x _____ OS _____ _____ x _____	Add _____ _____	**Visual Acuity** VA / HOTV ____/____ ____/____	Prism _____ _____

FOR DEPARTMENT USE ONLY

Authorization #: _____ Authorized _____

Other Procedure:	Approved	Denied
Exam/Refraction:	Approved	Denied
Lens (ES):	Approved	Denied
Frame:	Approved	Denied

Signature: _____

Reason: _____
Reason: _____
Reason: _____
Reason: _____
Date: _____

RETURN THIS FORM TO: **Anthony Mitchell, O.D.**
PO Box 1384, Williston, ND 58802-1384
Office Phone and FAX: 701-572-7444 • Home Telephone: 701-572-7727